# Financial Agreement

To our valued patients:

In order to keep our fees as low as possible we have implemented the following polices:

_____ Initial
- The parent or guardian who brings the patient to their visit is responsible for payment of any incurred charges on the date of service.

_____ Initial
- If the patient does not have dental insurance, payment in full is expected on the date of service. I agree the balance will be paid in full within 60 days of treatment, unless previous arrangements have been made. Should be account exceed ninety days, one percent (1%) interest per month, twelve percent (12%) per year will be charged.

_____ Initial
- If the patient does have dental insurance, the responsible party will pay the patient estimated portion and deductible on the day of service. As a courtesy to you, we will process your insurance forms and claims. **However, your insurance policy is an agreement you have with your insurance carrier. If you have questions regarding payments from your insurance company, we recommend that you call your insurance provider directly for the most accurate and speedy answer.** It is the parent's/guardian's responsibility to pay for any deductible or other balance not covered by your insurance. Regardless of insurance, I agree the balance will be paid in full within 60 days of treatment, unless previous arrangements have been made. Should my account exceed ninety days, one percent (1%) interest per month, twelve percent (12%) per year will be charged. St. George Kids Dental bills to hundreds of insurance companies. I understand that it is my responsibility to know and understand my benefits and limitations. I understand that the fees quoted are only an estimate. I understand that if my child has been referred by another dentist, my insurance may not cover the cost of exam or x-rays due to plan limitations, and it is my responsibility to pay.

_____ Initial
- If my child is covered under Medicaid insurance I agree that any uncovered services that are rendered or ineligible on the date of service would be my financial responsibility.

_____ Initial
- Upon examination, the doctor will prepare a treatment plan. The treatment plan is only an estimate of the dental care required and should not be construed as a statement of actual charges. I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient's examination.

_____ Initial
- It is my responsibility to update any dental insurance information with the office. I understand that if my insurance changes and is not updated in a timely manner, or if claim submission is outside of the payment window due to neglecting to update the info, the balance for the account will be responsibility.

_____ Initial
- There will be a $25 returned check fee assessed to your account on all returned checks.

_____ Initial
- All information given may be used to collect a debt. The responsible party agrees to pay all attorney fees and court cost associated with collecting payment for services rendered. Collection fees totaling approximately 50% are added to the account when it is turned over to a collection agency.

_____ Initial
- I authorize the dentist or his designees to release financially identifiable information, treatment descriptions, and information either electronically, by facsimile or paper form to my insurance carrier or any related entities that require such information.

_____ Signature of Responsible Party

_____ Printed Name

_____ Relationship to Child

_____ Date

_____ Patient Name(s)

St.George Kids Dental

For office use: _____

## Child's Information

Child's Name: _____ Today's Date: _____/_____/_____
First Last

Child's preferred name: _____ Child's Birthday: _____/_____/_____ Childs's Age: _____

Child's Home Address: _____ Male ☐ Female ☐

_____ Phone #: (_____) _____

## Parent Information

**Person Responsible for Account:** _____

Do you have legal custody of this child? Yes ☐ No ☐

Martial Status: Married ☐ Divorced ☐ Single ☐

**Father** ☐ **Step Father** ☐ **Guardian** ☐

Name: _____ Birthday: _____

S.S.#: _____ Cell Phone #: (____)_____

Address: (if different than child's) _____

_____

Email: _____

**Mother** ☐ **Step Mother** ☐ **Guardian** ☐

Name: _____ Birthday: _____

S.S.#: _____ Cell Phone #: (____)_____

Address: (if different than child's) _____

_____

Email: _____

## Child's Medical History

**Circle all that apply**

**Y N** Abnormal Bleeding
**Y N** ADD/ADHD
**Y N** Aids/HIV
**Y N** Anemia
**Y N** Artificial bones/joints
**Y N** Asthma
**Y N** Cancer
**Y N** Congenital Heart Defect
**Y N** Convulsions
**Y N** Diabetes
**Y N** Epilepsy
**Y N** Handicapped/Disabilities
**Y N** Hearing Impairment
**Y N** Heart Murmur
**Y N** Hepatitis
**Y N** High Blood Pressure
**Y N** Hives
**Y N** Kidney Problems
**Y N** Liver Problems
**Y N** Low Blood Pressure
**Y N** Lupus
**Y N** Measles
**Y N** Prosthetics
**Y N** Tuberculosis

List all medications child is currently taking:

_____

_____

List any other serious medical problems the child has:

_____

_____

List all child's allergies (including medications):

_____

_____

Latex allergy? Yes ☐ No ☐ Penicillin allergy? Yes ☐ No ☐

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA).

**Signature:** _____ **Print:** _____ **Date:** _____

I authorize St. George Kids Dental to release any information including the diagnosis and the records of any treatment or examination rendered to my child to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I authorize and request St. George Kids Dental to use "Signature on File" for my signature on all dental insurance forms to expedite computer processing of my claim. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment and/or copayment and/or deductible of all services rendered on mine or my dependents behalf.

**Signature:** _____ **Print:** _____ **Date:** _____